Mad in America
SCIENCE, PSYCHIATRY AND SOCIAL JUSTICE

Structural Competency and Social Medicine to Transform Global Mental Health

Helena Hansen advocates for integrating U.S. structural competency with Latin American social medicine to reshape mental healthcare into a vehicle for social change and justice.

By **Ally Riddle** - February 29, 2024

A new article published in Global Public Health puts social medicine traditions in conversation with one another to move beyond the confines of narrow biomedical and individualistic approaches and towards a broader commitment to social change. Hansen argues that by integrating principles from social medicine, particularly those developed in Latin America, structural competency can transform mental health care into a powerful tool for addressing systemic health inequities.

The author, Helena Hansen, a psychiatrist and anthropologist, is a professor and Chair of Psychiatry and Biobehavioral Sciences at the University of California, Los Angeles's David Geffen School of Medicine, as well as Interim Director of the Semel Institute for Neuroscience and Human Behavior.

Hansen writes to explore the relationship between the social medicine movements in Latin America and the United States' construct of structural competency.

One of her main questions in this article asks:

"What can U.S. structural competency advocates learn from the deep and rich social medicine traditions of Latin America? And is there anything that Latin American and other non-U.S. social medicine traditions might learn from U.S. structural competency?"

Hansen argues that **"cultivating allies within biomedicine can enhance the impact of community health movements and that cross-fertilizing U.S. Structural Competency and social medicine traditions across regions should be a priority for the fields."**

This approach advocates for a model of care that is not only responsive to individual needs but also actively engaged in challenging and changing the structures that perpetuate health disparities.

Structural competency is a term coined by Hansen and Jonathan Metzl, which describes the ability of healthcare professionals to recognize how institutions, neighborhood conditions, market forces, public policies, and healthcare delivery systems shape symptoms and diseases as well as organize to address and correct inequalities both in and outside of the clinical setting. Structural competency means biomedical practitioners must rely on the knowledge and skills of community organizers and those with lived experience of oppression to reduce inequalities.

Hansen explains how structural competency is a response to the current conditions in the U.S. These conditions have arisen due to adopting a privatized, profit-oriented approach to health care that looks to new devices and pharmaceuticals for a cure-all with policies and economic incentives that ignore social or structural causes of health problems. An ideology that is reproduced in

the education and training of U.S. health professionals who are rarely exposed to these concepts.

Hansen highlights numerous examples that demonstrate the informal practices, policies, and institutions in the United States that contribute to the reinforcement of embedded systemic racism. For instance, unjust drug laws lead to disparate law enforcement by neighborhoods and disparate sentencing by race, as well as the two-tiered system of U.S. health care that disproportionately excludes and channels Black, Indigenous, and Latino/a/e Americans from private hospitals and clinics into publicly funded, understaffed facilities. Through these examples, Hansen provides a compelling argument for how healthcare can be a window to see how racial categories are used in the contemporary economy as a result of racial capitalism being a significant component of the U.S. economy.

Racial Justice Movements as Social Medicine Innovators

Hansen writes that health care has long been a centerpiece of racial justice movements, which she highlights through examples of civil rights, LGBTQ+, Black, and Latino/a/e-led power movements, mainly when public officials neglected them. They resulted in successful national social medicine interventions. For example, Black community leaders worked with progressive doctors and nurses to create Federally Qualified Health Centers (FQHCs), the Black Panther Party established free clinics in Black urban communities, and the Young Lords Party, a Latino/a/e power movement demanded better funded, higher quality healthcare in the South Bronx.

It is clear how these grassroots health justice movements can help combat social drivers of health inequalities; however, how biomedical practitioners can intervene and provide support is less clear. Structural competency in medicine does not mean replacing these movements but calls on licensed professions to align with them and use their symbolic capital to **“redefine problems in areas that might be labeled social problems (housing and drug laws, transportation and food justice) as health problems.”**

In the article, Hansen demonstrates the potential for clinical collaboration with grassroots organizations, such as harm reduction organizations for individuals who use drugs, urban farming, and community gardening, as well as

reproductive justice movements that provide STI testing, contraception, abortion, and prenatal care for low-income women of color that involve community health workers, nurses, midwives, and obstetricians-gynecologists.

A Collaboration: U.S. Structural Competency and Social Medicine Traditions

Hansen ends the article by imagining the directions for collaboration amongst different social medicine traditions across regions. She calls for U.S. Structural Competency movements to learn from Latin American traditions that center the expertise of community organizers and people with lived experience and locate health interventions within grassroots community movements focused on migrant health, gender equality, and popular education with origins outside of biomedicine.

Latin American social medicine has a critique of the capitalist basis of biomedicine that the U.S. could learn from, as they highlight that **"biomedicine is embedded in systems of economics, policy, and power relations that necessarily produce pathological social inequalities,"** which this lens naturally redirects us to look towards grassroots community movements rather than biomedicine which has a reductionist approach to health care and reproduces health inequalities.

However, this is not to say that the knowledge and skills of licensed biomedical care cannot complement these actions and movements. Hansen argues that the collaboration between them "can enhance the impact and political power of these movements" and that **"structural intervention and cultural change can enable one another as necessary ingredients for justice in health."**

In conclusion, this article shows the potential for combating injustice in healthcare through the translation and adaptation of social medicine and structural competencies. Hansen, an international leader in social medicine, contributes significantly to movements that emphasize the power of mutual aid and grassroots actions and centers the experience of community health works and those with lived experience.

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